STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155688	A. BUILDING 01 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREELANDVILLE COMMUNITY HOME	310 W CARLISLE ST FREELANDVILLE, IN47535

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/01/11 Facility Number: 000355 Provider Number: 155688 AIM Number: 100273640 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Freelandville Community Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility with a basement was determined to be of	K0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance to the Life Safety Code Recertification Survey conducted on August 1, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 50 and had a census of 35 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/09/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0018 SS=F	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure 3 of 3 clean linen closets with double doors were equipped	K0018	**K018 It is the practice of Freelandville Community Home to assure that the linen closets with double doors are**	08/31/2011

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	with positive latches in 3 of 4 smoke compartments. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 08/01/11 between 10:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, all three sets of clean linen closet double doors in the A, B, and C halls were not equipped with positive latches. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 27 resident room doors would close completely and was smoke resistant. This deficient practice could affect any of the 13 residents, as well as staff and visitors in the A hall. Findings include:		**equipped with positive latches in smoke compartments for the protection of the residents, visitors, and staff. It is also our practice to assure that all resident doors are smoke resistant and close properly.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** There are no specific residents identified. The linen closet doors on A, B, and C halls have been corrected. In addition, the door to room #7 has been corrected. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be effected. All resident room doors have been checked and corrected if needed. All double doors throughout the building have been reviewed to assure that positive latches are in place as required. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The assessment of doors throughout the building has been placed on a preventive maintenance schedule to assure that all doors work in accordance with the regulations. The Maintenance Supervisor has been in-serviced related to this review and assuring that corrections are implemented if there are any findings. ***The corrective action taken to***	

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	Based on observation on 08/01/11 at 12:35 p.m. during a tour of the facility with the Maintenance Supervisor, resident room door # 7 did not close completely because the top hinge of the door was missing two screws which caused the door to droop. This caused a one half inch gap between the door and its frame when closed. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		***monitor performance to assure compliance through quality assurance is:*** The proper functioning and latching of doors will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring all doors throughout the building are reviewed on a quarterly basis for proper functioning and latching. Any identified issues will be immediately corrected. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance. ***The date the systemic changes will be completed:*** August 31, 2011	
K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 7 doors between smoke barriers was provided with	K0021	**K021 It is the practice of Freelandville Community Home to assure that doors between smoke barriers are provided with self-closures to ensure**	10/31/2011

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	a self closer to ensure the door would close automatically or upon activation of the fire alarm system or automatic sprinkler system. This deficient practice could affect any of the 35 residents, as well as staff and visitors while in the Dining Room. Findings include: Based on observation on 08/01/11 at 12:55 p.m. during a tour of the facility with the Maintenance Supervisor, the attic access stairway door from the Dining Room was not equipped with a self closer to ensure the door would close automatically or in the event the fire alarm system or the sprinkler system is activated. This was acknowledged by the Maintenance Supervisor at the time of observation. 3-1.19(b)		**that doors will automatically close as required. *The correction action taken for those residents found to be affected by the deficient practice include:*** There are no specific residents identified. The attic access door from the dining room will have a self-closure installed once the door is received. The facility is having a special size door individually made for this area. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be effected. All doors that could require self-closures have been reviewed and corrected if needed. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The doors that require review related to self-closing have been placed on the preventive maintenance schedule for quarterly review. The Maintenance Director has been in- serviced related to the following of the preventive maintenance plan and assuring that all necessary doors have self-closure as required by the regulations. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The review of doors requiring self-closures will	

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			be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that the self closures are completed in accordance with the schedule. Any identified issues will be immediately corrected. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance. ***The date the systemic changes will be completed:*** The facility respectfully requests an extension to extend the date certain because of awainting arrival of new custom made fire door that will take 5-6 weeks lead time to manufacture and 4 weeks to deliver. A safety round has been implemented daily to assure awareness of hazard. The estimated time of correction is October 31, 2011.	
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 3 smoke barrier walls	K0025	**K025** **Iti is tihe practice off tihis ffacilitiy tio assure tihati smoke barrier walls provide ati leasti ½ hour ffre**	08/31/2011

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	provided at least a one half hour fire resistance rating due to holes in the smoke barrier wall which were not fire stopped. This deficient practice could affect any of the 35 residents, as well as staff and visitors in the facility during time spent in the Dining Room or the front lounge/TV room. Findings include: Based on observation on 08/01/11 at 1:00 p.m. during a tour of the facility with the Maintenance Supervisor, the smoke barrier wall above the smoke barrier doors between the C hall and center smoke compartment had seven penetrations through the wall ranging in size from one to two inches around wire bundles, conduits, and sprinkler pipes. 3.1-19(b)		**resistiance in accordance witih tihe code.** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no speciftc residentts identtfted. The barrier wall identtfted on C hall has been repaired. ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted All barrier walls have been reviewed tto assure tthatt tthere are no penettrattons in tthe barrier ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** Barrier walls have been added tto tthe preventtve mainttenance program ftor quartterly reviews The mainttenance Directtor has been in serviced relatted tto tthe ftollowing oft tthe preventtve mainttenance plan ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The barrier wall reviews will be monittored as partt oft tthe preventtve mainttenance review att tthe quartterly QA meettngs. The Mainttenance Directtor, or designee, will be responsible ftor assuring tthatt tthe barrier walls have no penettrattons Any identtfted issues will be immediattely correctted The	

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			Administtrattorr designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance. ***The date the systemic changes will be completed:*** Augustt31, 2011	
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 7 doors between smoke barriers was at least a 20 minute fire rated door or at least a 1 3/4-inch thick solid bonded wood core door. This deficient practice could affect any of the 35 residents, as well as staff and visitors while in the Dining Room. Findings include: Based on observation on 08/01/11 at 12:55 p.m. during a tour of the facility with the Maintenance Supervisor, the stairway door to the attic from the	K0027	**K027 It is the practice of Freelandville Community Home to assure that doors between smoke barriers are at least a 20 minute fire rated door or at least a 1 3/4 inch thick solid bonded wood core door.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** There are no specific residents identified. The stairway door to the attic from the dining room is being replaced with at least a 20 minute fire rated door. This door has to be especially made because of the size of the door. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be effected. All smoke barrier doors have been reviewed to	10/31/2011

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	Dining Room was a hollow core door with no fire rating tag. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		assure that they have proper fire ratings. Please refer to systems implemented to assure compliance with this tag. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The smoke barrier doors have been added to the preventive maintenance program on a quarterly basis to assure that they work properly and have proper fire resistance. The maintenance Director has been in- serviced related to the following of the preventive maintenance plan. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The smoke barrier doors will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that the barrier doors are of the proper fire rating. Any identified issues will be immediately corrected. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance. ***The date the systemic changes will be completed:*** The facility respectfully requests an extention to extend the date certain. This door had to be custom made because of the odd size. This will take 5-6 weeks to	

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			manufacture and another 4 weeks for deliverly. A safety round has been implemented daily to assure awareness of hazard. The estimated time of correction is October 31, 2011.	
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 3 of 6 hazardous area room doors such as rooms over 50 square feet containing combustible material were equipped with self closing devices on the doors. This deficient practice could affect any of the 35 residents, as well as staff and visitors in all three sleeping room corridors. Findings include: Based on observations on 08/01/11 between 10:45 a.m. and 1:30 p.m. during a tour of the facility with Maintenance	K0029	**K029 It is the practice of Freelandville Community Home to assure that doors to hazardous areas over 50 square feet that contain combustible material have self-closing devices.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** There are no specific residents identified. The 3 doors identified in the 2567 are being replaced because the self-closing devices that were installed did not work properly on the doors. These doors have been ordered and are expected to be available for installation in approximately 6 weeks. ***Other residents that have the potential to be affected have been identified by:*** Potentially all	10/31/2011

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	Supervisor, the following hazardous area room doors were not provided with self closing devices: the A, B, and C hall shower rooms which each contained two soiled linen barrels over thirty two gallons total capacity containing soiled linen. This was acknowledged by the Maintenance Supervisor at the time of each observation, furthermore, the Maintenance Supervisor indicated the soiled linen barrels were normally kept in the three shower rooms. 3.1-19(b)		residents could be effected. All doors that are present in hazardous areas have been reviewed to assure that they have self-closing devices in place. Please refer to systems implemented to assure compliance with this tag. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The doors to the hazardous areas have been added to the preventive maintenance program on a quarterly basis to assure that they have properly working self-closing devices. The maintenance Director has been in- serviced related to the following of the preventive maintenance plan. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The doors to the hazardous areas will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that the self-closing devices on the doors function properly. Any identified issues will be immediately corrected. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance. ***The date the systemic changes will be completed:*** The facility	

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			respectfully requests aan extention to extend the date certain. Doors and frames had to be ordered. This will take 6 weeks for deliverly and installation. A safety round has been implemented daily to assure awareness of hazard. The estimated time of correction is October 31, 2011.	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 2 of 6 exit access doors in the existing building supplied with delayed egress locks and provided with signs indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, released from their magnetic holders within 15 seconds after pushing the panic bar. LSC 7.2.1.6.1, says approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through	K0038	**K038** **Iti is tihe practice off Freelandville Communitiy Home tio assure tihati exiti doors release properly as a delayed egress in accordance witih tihe regulation** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no speciftc residentts identtfted. The doors identtfted on C hall and tthe Dining Room have had Relay Swittches replaced and now work appropriattely ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted All exitt doors have been reviewed tto assure tthatt tthe delayed egress locks work appropriattely ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The doors identttfted as exitt areas are being reviewed tto assure tthatt	08/31/2011

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	42, provided the following criteria are met: (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d)		delayed egress locks are working properly as partt oft tthe preventtve mainttenance plan on a quartterly basis The mainttenance Directtor has been in- serviced relatted tto tthe ftollowing oft tthe preventtve mainttenance plan ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The delayed egress locks att tthe exitt areas will be monittored as partt oft tthe preventtve mainttenance review att tthe quartterly QA meettngs The Mainttenance Directtor or designee, will be responsible ftor assuring tthatt tthe delayed egress locks on tthe exitt doors are operattng properly. Any identtfted issues will be immediattely correctted The Administtrattor or designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance ***The date the systemic changes will be completed:*** Augustt31, 2011	

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	155688	A. BUILDING 01 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREELANDVILLE COMMUNITY HOME	310 W CARLISLE ST FREELANDVILLE, IN47535

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On the door adjacent to the releasing device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect any of the 35 residents, as well as staff and visitors while in the Dining Room. Findings include: Based on observation on 08/01/11 between 10:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, the C hall exit door and the Dining Room middle exit door were both equipped with delayed egress locks with signs indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. These doors did not release from their magnetic holders within fifteen seconds when tested, however, they both did release when the five digit code was pushed. This was acknowledged by the Maintenance			

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	Supervisor at the time of each observation. 3.1-19(b)			
K0050 SS=C	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills in the Fire Alarm Information book on 08/01/11 at 9:15 a.m. with the Maintenance Supervisor present, four of four, second shift fire drills since July of 2010 were performed between the hours of 2:20 p.m. and 3:05 p.m. During an interview at the time of	K0050	**K050** **Iti is tihe practice off tihis ffacilitiy tio assure tihati ffre drills are conductied ati leasti quartierly on each shiff** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no specifitc residentts identtfted. Please see under systtems implementted tto assure compliance witth tthis ttag ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems implementted tto assure compliance witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A ftre drill has been conductted ftor	08/31/2011

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	record review, the Maintenance Supervisor acknowledged the times of all four second shift fire drills. 3-1.19(b)		each shift per quartter in2011. The ftre drills are scheduled per tthe preventtve maintttenance schedule tto be held each shift quartterly. The Mainttenance Directtor has been in-serviced relatted tto tthe sttaggering oft ttmes witthin tthe required shifts tto inittatte tthe ftre drills ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The ftre drills will be monittored as partt oft tthe preventtve maintttenance review att tthe quartterly QA meettngs. The Mainttenance Directtor, or designee, will be responsible ftor assuring tthatt tthe ftre drills are completted in accordance witth tthe schedule and tthatt shifts are appropriattely sttaggered. Any identtfted issues will be immediattely correctted. The Administtrattor, or designee, will review tthe preventtve maintttenance documenttatton quartterly ftor compliance. ***The date the systemic changes will be completed:*** Augustt31, 2011	

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K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and	K0051	**K051** **Iti is tihe practice off tihis ffacilitiy tio assure tihati tihe ffre alarm contirol panel works appropriatiely including an audible tirouble signal iff tihere is a problem witih tihe systiem** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no specifitc residentts identtfted. The ftre systtem panel is going tto be updatted.The updatte will assure tthatt tthere is an audio alertt tto problems as well as tthe litt indicattor ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems	12/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	descriptively annunciated. This deficient practice could affect all residents, staff and visitors in the existing portion of the facility. Findings include: Based on observation on 08/01/11 during the alarm test at 1:30 p.m. with the Maintenance Supervisor, the Digital Alarm Communicator Transmitter (DACT) next to the fire alarm control panel (FACP) at the Nurses' Station was placed in trouble from phone line failure (phone line #1). The DACT did illuminate a yellow trouble signal, however, there was no local audio trouble signal initiated by the DACT. Based on interview on 08/01/11 at 1:35 p.m., the Maintenance Supervisor acknowledged the phone line failure did illuminate a trouble signal, but, did not initiate a local audio trouble signal, furthermore, at 1:45 p.m., the Maintenance Supervisor indicated the phone line failure was received by the fire alarm monitoring company. 3.1-19(b)		implementted tto assure compliance witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A ftre vendor will be insttalling updattes tto tthe currentt ftre panel The new systtem will allow ftor audio alertts ftor any problems in tthe systtem The ftacilitty sttaft will be in-serviced once tthis systtem is insttalled ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The updatted ftre alarm systtem will be monittored by tthe Mainttenance Directtor as partt oft tthe preventtve mainttenance program In additton, tthe ftre vendor will also be involved witth routtne ttesttng oft tthe systtem in accordance witth tthe regulattonAny identtfted issues will be immediattely correctted The Administtrattorror designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance ***The date the systemic changes will be completed:*** The ftacilitty respecttully requestts a waiver tto exttend tthe datte certtain The esttmatted ttme oft correctton is December 31, 2011.	

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	Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors in the existing portion of the facility. Findings include: Based on observation on 08/01/11 during the alarm test at 1:30 p.m. with the Maintenance Supervisor, the Digital Alarm Communicator Transmitter (DACT) next to the fire alarm control panel (FACP) at the Nurses' Station was placed in trouble from phone line failure (phone line #1). The	K0051	**K051** **Iti is tihe practice off tihis ffacilitiy tio assure tihati tihe ffre alarm contirol panel works appropriatiely including an audible tirouble signal iff tihere is a problem witih tihe systiem** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no speciftc residentts identtfted. The ftre systtem panel is going tto be updatted.The updatte will assure tthatt tthere is an audio alertt tto problems as well as tthe litt indicattor ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems implementted tto assure compliance witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A ftre vendor will be insttalling updattes tto tthe currentt ftre panel The new systtem will allow ftor audio alertts ftor any problems in tthe systtem The ftacilitty sttaft will be in-serviced once tthis systtem is insttalled ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The updatted ftre alarm systtem will be monittored by tthe Mainttenance	12/31/2011

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	DACT did illuminate a yellow trouble signal, however, there was no local audio trouble signal initiated by the DACT. Based on interview on 08/01/11 at 1:35 p.m., the Maintenance Supervisor acknowledged the phone line failure did illuminate a trouble signal, but, did not initiate a local audio trouble signal, furthermore, at 1:45 p.m., the Maintenance Supervisor indicated the phone line failure was received by the fire alarm monitoring company. 3.1-19(b)		Directtor as partt oft tthe preventtve maintttenance program In addittion, tthe ftre vendor will also be involved witth routtne ttesttng oft tthe systtem in accordance witth tthe regulattonAny identtfted issues will be immediattely correctted The Administtrattorror designee, will review tthe preventtve maintttenance documenttatton quartterly ftor compliance ***The date the systemic changes will be completed:*** The ftacilitty respecttully requestts a waiver tto exttend tthe datte certtain The esttmatted ttme oft correctton is December 31, 2011.	
K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 2 areas outside and attached to the building and constructed of	K0056	**K056** **Iti is tihe practice off tihis ffacilitiy tio assure tihati tihe all necessary areas are sprinkled properly in accordance witih tihe regulation** ***The correcton acton taken fior***	12/31/2011

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	combustible material. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs exceeding four feet in width. This deficient practice could affect any of the 35 residents, staff, or visitors in the facility during time spent in the Dining Room if needing to exit through the two Dining Room exits to the outside. Findings include: Based on observation on 08/01/11 at 10:50 a.m. during a tour of the facility with the Maintenance Supervisor, the side porch off of the Dining Room had a thirty six foot by nine foot overhang. This overhang was constructed of wood framing above the metal covered overhang and was not provided with sprinkler coverage. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1-19(b)		***those residents fiound to be afiected by the deficient practce include :*** There are no speciftc residentts identtfted. The side overhang nextt tto tthe dining room will be sprinkled as partt oft updattes in tthe ftre systtem ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted. Please refter tto systtems implementted tto assure compliance witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A ftre vendor will be insttalling updattes tto tthe currentt ftre systtem including tthe additton oft sprinklers tto areas tthatt require tthis intterventton. The ftacilitty sttaft will be in-serviced once tthe sprinklers are insttalled ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The updatted sprinkler systtem will be monittored by tthe Mainttenance Directtor as partt oft tthe preventtve mainttenance program. In additton, tthe ftre vendor will also be involved witth routtne ttesttng oft tthe systtem in accordance witth tthe regulatton. Any identtfted issues will be immediattely correctted. The Administtratto,or designee, will review tthe preventtve mainttenance documenttatton	

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			quartterly ftor compliance ***The date the systemic changes will be completed:*** The ftacilitty respecttully requestts a waiver tto exttend tthe datte certtain The esttmatted ttme oft correctton is December 31, 2011.	
K0062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
	1. Based on observation and interview, the facility failed to ensure 8 of over 300 sprinkler heads in the facility were free of paint. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint. Any sprinkler shall be replaced that is painted. This deficient practice could affect any of the 35 residents, as well as staff and visitors while in the Dining Room or kitchen. Findings include: Based on observations on 08/01/11 between 11:00 a.m. and 11:20 a.m. during a tour of the facility with the Maintenance	K0062	**K062** **Iti is tihe practice off Freelandville Communitiy Home tio assure tihati all sprinklers are maintiained appropriatiely and tihati and tihati tihere is a spare sprinkler head ffor tihe tiypes off sprinklers utilized in tihe ffacilitiy** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no specifitc residentts identtfted. The sprinkler heads identtfted as having paintt on tthem in tthe 2567have been replaced. In additton, spare sprinkler heads have been purchased tthatt are oft tthe same ttype tthatt is uttlized in tthe building tto assure tthatt tthere are 2 oft each ttype oft needed. ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems implementted tto assure compliance witth tthis ttag ***The measures or systematc***	08/31/2011

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	Supervisor, the following areas had sprinkler heads partially covered with paint: six of fifteen sprinkler heads in the Dining Room and two of four sprinkler heads in the kitchen. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler head storage cabinets was provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observation on 08/01/11 at 11:19 a.m. during a tour of the facility with the		***changes that have been put into place to ensure that the deficient practce does not recur include :*** The preventtve mainttenance plan has been updatted tto assure tthatt sprinkler heads are reviewed and are in good operattng conditton. In additton, sprinkler spare inventtory has also been added tto tthe preventtve mainttenance plan tto assure tthatt tthere is a minimum of 2 spare sprinkler heads ftor each ttype uttlized in tthe building. The mainttenance supervisor has been in-serviced relatted tto tthe review oft sprinkler heads on a quartterly basis as partt oft tthe preventtve mainttenance plan ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The sprinkler heads will be monittored by tthe Mainttenance Directtor as partt oft tthe preventtve mainttenance program on a quartterly basis. Any identtfted issues will be immediattely correctted. The Administtrattor, or designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance. ***The date the systemic changes will be completed:*** Augustt 31, 2011	

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	Maintenance Supervisor, the spare sprinkler head cabinet had eight spare sprinkler heads, but, only included one side wall sprinkler head and one pendent type sprinkler head. The remaining sprinkler heads were upright type sprinkler heads. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor indicated there were no other side wall or pendent type spare sprinkler heads in the facility. 3-1.19(b)			
K0069 SS=B	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, interview and observation; the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces	K0069	**K069** **Iti is tihe practice off Freelandville Communitiy Home tio assure tihati tihe kitichen exhausti systiem is cleaned semiannually.** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no speciftc residentts identtfted. The exhaustt systtem has been tthoroughly cleaned ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems	08/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FREELANDVILLE COMMUNITY HOME	310 W CARLISLE ST FREELANDVILLE, IN47535

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen. Findings include: Based on review of the kitchen range inspection reports in the Fire Alarm Information book on 08/01/11 at 10:00 a.m. with the Maintenance Supervisor present, there was no documentation to show the kitchen range hood had been cleaned within the past six months. Based on observation at 11:15 a.m. during a tour of the facility with the Maintenance Supervisor, there was a sticker on the kitchen range hood which indicated the range hood was		implementted tto assure compliance witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The preventtve maintttenance plan has been updatted tto assure tthatt tthe kittchen exhaustt systtem is cleaned semiannually in accordance witth tthe regulatton. The mainttenance supervisor has been in-serviced relatted tto semiannual cleaning oft tthe exhaustt systtem ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The kittchen exhaustt systtem will be monittored by tthe Mainttenance Directtor as partt oft tthe preventtve maintttenance program on a quartterly basis. Any identtfted issues will be immediattely correctted The Administtrattor,or designee, will review tthe preventtve maintttenance documenttatton quartterly ftor compliance. ***The date the systemic changes will be completed:*** Augustt31, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	cleaned in October of 2010 with the next scheduled cleaning due in October of 2011. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1-19(b)			
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure the door to 1 of 1 oxygen storage rooms where oxygen transferring takes place was provided with a self closing device. This deficient practice could affect 13 residents, as well as staff and visitors in the A hall. Findings include:	K0143	**K143** **Iti is tihe practice off Freelandville Communitiy Home tio assure tihati doors tio tihe oxygen room have selffclosures** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no specifitc residentts identtfted. The oxygen room has had selftclosure devices insttalled ***Other residents that have the potental to be afiected have been identfied by :***	08/31/2011

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	Based on observation on 08/01/11 at 12:20 p.m. during a tour of the facility with the Maintenance Supervisor, the oxygen storage/transfer room was not provided with a self closing device. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor indicated oxygen transferring takes place in the oxygen storage/transfer room. 3.1-19(b)		Pottenttally all residentts could be eftectted Please see systtemattc changes below tto assure correctton ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The oxygen door has been placed on tthe preventtve mainttenance plan. This will assure tthatt tthe self-locking closure tthatt was insttalled is working properly as partt oft tthe preventtve mainttenance plan on a quartterly basis The mainttenance Directtor has been in- serviced relatted tto tthe ftollowing oft tthe preventtve mainttenance plan ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The preventtve mainttenance plans will be reviewed att tthe quartterly QA meettngs. The Mainttenance Directtor, or designee, will be responsible ftor assuring tthatt tthe selft-closing door tto tthe oxygen room is operattng properly. Any identtfted issues will be immediattely correctted The Administtrattor, or designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance ***The date the systemic changes will be completed:*** Augustt31, 2011	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			

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	1. Based on observation and interview, the facility failed to ensure 2 of 2 emergency generators were provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature.	K0144	**K144** **Iti is tihe practice off Freelandville Communitiy Home tio assure tihati tihe generatior is checked in accordance witih tihe regulatiory guidelines and has alarm annunciatior ati a regular work stiation is equipped witih a remotie manual stiop and tio assure tihati any off-sitie ffuel utilized is ffrom a reliable source.** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no specifitc residentts identtfted. Please see under systtems implementted tto assure compliance witth tthis ttag ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems implementted tto assure compliance witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A remotte alarm annunciattor ftor each generattor will be insttalled in a locatton readily observed by operattng personnel att tthe nurses' sttatton All sttaft will be inserviced on tthe alarm annunciattor once itt has been insttalled A remotte shutt oft swittch ftor tthe generattor will be insttalled in	12/31/2011

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	4. Low fuel – when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all residents, as well as visitors and staff in the existing portion of the facility. Findings include: Based on observations on 08/01/11 between 10:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, a remote alarm annunciator for the each generator was not provided in a location readily observed by operating personnel at a regular work station such as a nurses' stations or any other area in the facility.		accordance witth tthe regulattonAll sttaft will be inserviced on tthe new insttallatton oft tthe remotte shutt oft swittch tto assure tthatt all sttaft would have knowledge oft how tto remottely sttop tthe generattor ift necessary A letter has been received ftrom tthe oft-sitte gas company tthatt provides ftuel ftor tthe smaller generattor as evidence oft reliabilitty oft tthe nattural gas supplier ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The newly insttalled alarm annunciattor and remotte shutt oft systtem will be monittored as partt oft tthe preventtve mainttenance plan on a quartterly basis The Mainttenance Directtor, or designee, will be responsible ftor assuring tthatt tthe newly insttalled annunciattor and remotte shutt oft ftor tthe generattor is routtnely checked and operattonal In additton, preventtve mainttenance will also include assuring tthatt a letter oft reliabilitty is in place ftrom tthe outtside vendor tthatt provides tthe ftuel ftor tthe generattorAny identtfted issues will be immediattely correctted The Administtratto,ror designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance ***The date the systemic changes will be completed:*** The ftacilitty respecttully requestts a waiver tto exttend tthe datte certtain	

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	During an interview on 08/01/11 at 1:30 p.m., the Maintenance Supervisor acknowledged there were no remote alarm annunciators for each emergency generator at the nurses' station or any other area in the facility. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c)		The esttmatted ttme oft correctton is December 31, 2011.	

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	requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants in the facility. Findings include: Based on observation on 08/01/11 between 10:45 a.m. and 1:30 a.m. during a tour of the facility with the Maintenance Supervisor, evidence of a remote shut off device was not found for the generator. Based on interview at 12:00 p.m. on 08/01/11, the Maintenance Supervisor indicated the large generator was over 100 horsepower and was installed after 2003, and further indicated there was no remote shut off device for the generator. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the off site fuel source for 1 of 2 emergency generators was from a reliable source. NFPA 110, 1999 Edition, Standard for			

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	Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. CMS requires evidence of reliability of the natural fuel source must contain all of the following: a. A statement of reasonable reliability of the natural gas delivery;			

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	b. A brief description the supports the statement regarding the reliability; c. A statement there is a low probability of interruption of the natural gas; d. A brief description that supports the statement regarding the low probability of interruption; e. The signature of technical personnel from the natural gas vendor. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation on 08/01/11 at 11:25 a.m. during a tour of the facility with the Maintenance Supervisor, the small emergency generator in the basement was powered with natural gas only. This was acknowledged by the Maintenance Supervisor at the time of observation. During an interview at 1:45 p.m. the Administrator indicated the facility did not have a letter from their natural gas			

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	provider as evidence of reliability of their natural gas supply. 3.1-19(b)			
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/01/11 Facility Number: 000355 Provider Number: 155688 AIM Number: 100273640 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Freelandville Community Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The	K0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance to the Life Safety Code Recertification Survey conducted on August 1, 2011.	

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	2008 addition consisted of the Ambulance Bay which was surveyed with Chapter 18, New Health Care Occupancies. This one story addition was determined to be of Type V (111) construction and was not sprinklered. This addition is connected to the facility's fire alarm system with smoke detectors in the Ambulance Bay. The facility has a capacity of 50 and had a census of 35 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0050 SS=C	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to	K0050	**K050** **Iti is tihe practice off tihis ffacilitiy tio assure tihati ffre drills are conductied**	08/31/2011

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	ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents while in the Ambulance Bay portion of the facility. Findings include: Based on review of the facility's fire drills in the Fire Alarm Information book on 08/01/11 at 9:15 a.m. with the Maintenance Supervisor present, four of four, second shift fire drills since July of 2010 were performed between the hours of 2:20 p.m. and 3:05 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times of all four second shift fire drills. 3-1.19(b)		**ati leasti quartierly on each shiff** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no specifitc residentts identtfted. Please see under systtems implementted tto assure compliance witth tthis ttag ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems implementted tto assure compliance witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A ftre drill has been conductted ftor each shift per quartter in2011. The ftre drills are scheduled per tthe preventtve mainttenance schedule tto be held each shift quartterly The Mainttenance Directtor has been in serviced relatted tto tthe sttaggering oft ttmes witthin tthe required shifts tto inittatte tthe ftre drills ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The ftre drills will be monittored as partt oft tthe preventtve mainttenance review att tthe quartterly QA meettngs. The Mainttenance Directtor, or designee, will be responsible ftor assuring tthatt tthe ftre drills are completted in accordance	

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			witth tthe schedule and tthatt shifts are appropriattely sttaggered Any identtfted issues will be immediattely correctted The Administtrattorror designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance ***The date the systemic changes will be completed:*** Augustt31, 2011	
K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. NFPA 72,	K0051	**K051** **Iti is tihe practice off tihis ffacilitiy tio assure tihati tihe ffre alarm contirol panel works appropriatiely including an audible tirouble signal iff tihere is a problem witih tihe systiem** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no specifitc residentts identtfted The ftre systtem panel is going tto be updatted The updatte will assure tthatt tthere is an audio	12/31/2011

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	155688	A. BUILDING 02 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREELANDVILLE COMMUNITY HOME	310 W CARLISLE ST FREELANDVILLE, IN47535

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	1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect any number of residents, staff and visitors while in the Ambulance Bay portion of the facility. Findings include: Based on observation on 08/01/11 during the alarm test at 1:30 p.m. with the Maintenance Supervisor, the Digital Alarm Communicator Transmitter (DACT) next to the fire alarm control panel (FACP) at the Nurses' Station was placed in trouble from phone line failure (phone line #1). The DACT did illuminate a yellow trouble signal, however, there was no local audio trouble signal initiated by the DACT. Based on interview on 08/01/11 at 1:35 p.m. the Maintenance Supervisor acknowledged the phone line failure did illuminate a trouble signal, but, did not initiate a local audio trouble signal, furthermore,		alertt tto problems as well as tthe litt indicattor ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems implementted tto assure compliance witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A ftre vendor will be insttalling updattes tto tthe currentt ftre panel The new systtem will allow ftor audio alertts ftor any problems in tthe systtem The ftacilitty sttaft will be in-serviced once tthis systtem is insttalled ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The updatted ftre alarm systtem will be monittored by tthe Mainttenance Directtor as partt oft tthe preventtve mainttenance program In additton, tthe ftre vendor will also be involved witth routtne ttesttng oft tthe systtem in accordance witth tthe regulattonAny identtfted issues will be immediattely correctted The Administtrattorror designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance ***The date the systemic changes will be completed:*** The ftacilitty respecttully requestts a	

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	at 1:45 p.m., the Maintenance Supervisor indicated the phone line failure was received by the fire alarm monitoring company. 3.1-19(b)		waiver tto exttend tthe datte certtain The esttmatted ttme oft correctton is December 31, 2011.	
K0056 SS=E	There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. Based on observation and interview, the facility failed to provide an automatic sprinkler system which provided complete coverage in 1 of 1 smoke compartments in the new portion of the facility. This deficient practice could affect any number of residents, as well as staff and visitors while in the Ambulance Bay. Findings include: Based on observation on	K0056	**K056** **Iti is tihe practice off tihis ffacilitiy tio assure tihati tihe all necessary areas are sprinkled properly in accordance witih tihe regulation** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no specifitc residentts identtfted. The side overhang nextt tto tthe dining room will be sprinkled as partt oft updattes in tthe ftre systtem ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems implementted tto assure compliance	12/31/2011

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	08/01/11 at 11:45 a.m. during a tour of the facility with the Maintenance Supervisor, the Ambulance Bay was connected to the existing portion of the facility by a sprinklered corridor, however, the Ambulance Bay was not provided with automatic sprinkler coverage. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor confirmed the facility uses the Ambulance Bay for transporting residents to and from the facility. 3.1-19(b)		witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A ftre vendor will be insttalling updattes tto tthe currentt ftre systtem including tthe additton oft sprinklers tto areas tthatt require tthis inttervention. The ftacilitty sttaft will be in-serviced once tthe sprinklers are insttalled ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The updatted sprinkler systtem will be monittored by tthe Mainttenance Directtor as partt oft tthe preventtve mainttenance program. In additton, tthe ftre vendor will also be involved witth routtne ttesttng oft tthe systtem in accordance witth tthe regulatton. Any identtfted issues will be immediattely correctted. The Administratto, or designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance ***The date the systemic changes will be completed:*** The ftacilitty respecttully requestts a waiver tto exttend tthe datte certtain The esttmatted ttme oft correctton is December 31, 2011.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and	K0144	**K144** **Iti is tihe practice off Freelandville**	12/31/2011

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	interview, the facility failed to ensure 2 of 2 emergency generators were provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel		**Communitiy Home tio assure tihati tihe generatior is checked in accordance witih tihe regulatiory guidelines and has alarm annunciatior ati a regular work stiation, is equipped witih a remotie manual stiop and tio assure tihati any off-sitie ffuel utilized is ffrom a reliable source.** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** There are no speciftc residentts identtfted. Please see under systtems implementted tto assure compliance witth tthis ttag ***Other residents that have the potental to be afiected have been identfied by :*** Pottenttally all residentts could be eftectted Please refter tto systtems implementted tto assure compliance witth tthis ttag ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** A remotte alarm annunciattor ftor each generattor will be insttalled in a locatton readily observed by operattng personnel att tthe nurses' sttatton. All sttaft will be inserviced on tthe alarm annunciattor once itt has been insttalled A remotte shutt oft swittch ftor tthe generattor will be insttalled in accordance witth tthe regulattonAll sttaft will be inserviced on tthe new	

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	storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all residents, as well as visitors and staff while in the Ambulance Bay portion of the facility. Findings include: Based on observations on 08/01/11 between 10:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, a remote alarm annunciator for the each generator was not provided in a location readily observed by operating personnel at a regular work station such as a nurses' stations or any other area in the facility.		insttallatton oft tthe remotte shutt oft swittch tto assure tthatt all sttaft would have knowledge oft how tto remottely sttop tthe generattor ift necessary A letter has been received ftrom tthe oft-sitte gas company tthatt provides ftuel ftor tthe smaller generattor as evidence oft reliabilitty oft tthe nattural gas supplier ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** The newly insttalled alarm annunciattor and remotte shutt oft systtem will be monittored as partt oft tthe preventtve mainttenance plan on a quartterly basis The Mainttenance Directtor, or designee, will be responsible ftor assuring tthatt tthe newly insttalled annunciattor and remotte shutt oft ftor tthe generattor is routtnely checked and operattonal. In additton, preventtve mainttenance will also include assuring tthatt a letter oft reliabilitty is in place ftrom tthe outtside vendor tthatt provides tthe ftuel ftor tthe generattor. Any identtfted issues will be immediattely correctted The Administrattor, or designee, will review tthe preventtve mainttenance documenttatton quartterly ftor compliance. ***The date the systemic changes will be completed:*** The ftacilitty respecttully requestts a waiver tto exttend tthe datte certtain The esttmatted ttme oft correctton is December 31, 2011.	

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	During an interview on 08/01/11 at 1:30 p.m., the Maintenance Supervisor acknowledged there were no remote alarm annunciators for each emergency generator at the nurses' station or any other area in the facility. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c)			

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	requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, as well as visitors and staff while in the Ambulance Bay portion of the facility. Findings include: Based on observation on 08/01/11 between 10:45 a.m. and 1:30 a.m. during a tour of the facility with the Maintenance Supervisor, no evidence of a remote shut off device was found for the generator. Based on interview at 12:00 p.m., the Maintenance Supervisor indicated the large generator was over 100 horsepower and was installed after 2003, and further indicated there was no remote shut off device for the generator. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the off site fuel source for 1 of 2 emergency generators was			

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	from a reliable source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. CMS requires evidence of reliability of the natural fuel source must contain all of the following: a. A statement of reasonable			

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	reliability of the natural gas delivery; b. A brief description the supports the statement regarding the reliability; c. A statement there is a low probability of interruption of the natural gas; d. A brief description that supports the statement regarding the low probability of interruption; e. The signature of technical personnel from the natural gas vendor. This deficient practice could affect all residents, as well as visitors and staff while in the Ambulance Bay portion of the facility. Findings include: Based on observation on 08/01/11 at 11:25 a.m. during a tour of the facility with the Maintenance Supervisor, the small emergency generator in the basement was powered with natural gas only. This was acknowledged by the Maintenance Supervisor at the time of			

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	observation. During an interview at 1:45 p.m. the Administrator indicated the facility did not have a letter from their natural gas provider as evidence of reliability of their natural gas supply. 3.1-19(b)			